



# **Department of Veterans Affairs Office of Inspector General**

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## **Combined Assessment Program Review of the VA Medical Center San Juan, Puerto Rico**

## **Office of Inspector General**

### **Combined Assessment Program Reviews**

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care and benefits services are provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections, Audit, and Investigations to provide collaborative assessments of VA medical facilities and regional offices on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical and benefits services.
- Determine if management controls ensure compliance with regulations and VA policies, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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## **Executive Summary**

### **Introduction**

During the week of April 18-22, 2005, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Medical Center (the medical center), San Juan, Puerto Rico (PR). The purpose of the review was to evaluate selected operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we provided 5 fraud and integrity awareness briefings to 1,004 employees. The medical center is under the jurisdiction of Veterans Integrated Service Network (VISN) 8.

### **Results of Review**

We identified an organizational strength in the Nursing Home Care Unit (NHCU).

The CAP review focused on 11 areas. The medical center complied with selected standards in the following five areas:

- Contract Administration
- Controlled Substances Accountability
- Environment of Care
- Part-Time Physician Time and Attendance
- Pressure Ulcer Clinical Practices

We identified six areas that needed management attention. To improve operations, the following recommendations were made:

- Improve controls over information technology (IT) security.
- Improve controls over supply inventory management.
- Conduct reviews of government purchase cards.
- Improve colorectal cancer management.
- Complete patient safety aggregate reviews.
- Improve procedures for the Medical Care Collections Fund.

This report was prepared under the direction of Ms. Victoria Coates, Director, and Ms. Christa Sisterhen, CAP Review Coordinator, Office of Healthcare Inspections.

## **VISN and Medical Center Directors' Comments**

The VISN and Medical Center Directors agreed with the findings and recommendations and provided acceptable implementation plans. (See pages 18–27 for the full text of the Directors' comments.) We will follow up on planned actions until they are completed.

*(original signed by:)*

**JON A. WOODITCH**  
Acting Inspector General

## Introduction

### Facility Profile

**Organization.** The VA Medical Center located in San Juan, PR, is a large tertiary care facility that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at satellite clinics located in Ponce and Mayaguez. There are community-based outpatient clinics (CBOCs) in St. Thomas and St. Croix in the U.S. Virgin Islands and in Arecibo and Guayama, PR. The medical center is part of VISN 8 and serves a veteran population of about 150,000 in Puerto Rico and the U.S. Virgin Islands.

**Programs.** The medical center provides medical, surgical, mental health, geriatric, rehabilitation, spinal cord injury, and dentistry services. The medical center has 331 acute care hospital beds, 12 blind rehabilitation beds, and 149 Nursing Home Care Unit (NHCU) beds (including 29 transitional beds). The medical center also has a sharing agreement with the U.S. Army Health Clinic at the Ft. Buchanan military base.

**Affiliations and Research.** The medical center is affiliated with the three Liaison Committee for Medical Education (LCME) accredited medical schools in Puerto Rico: University of Puerto Rico (UPR), Ponce School of Medicine, and the Universidad Central del Caribe Medical Schools; it supports 800 trainees, medical residents, interns, and student training programs. There are 136 VA paid medical residents from 21 different specialty residency training programs. Affiliations include the UPR Dental, Pharmacy, Nursing, and Allied Health Professional Schools. In fiscal year (FY) 2004, the medical center research program had 47 research principal investigators working on 161 approved research projects. The total research funding for FY 2004 was \$1.5 million. Important areas of research include hematology and oncology, infectious diseases, diabetes, and spinal cord injury, among others.

**Resources.** In FY 2004, medical care expenditures totaled \$346 million. The FY 2005 medical care budget is \$349 million. FY 2004 staffing totaled 3,269 full-time equivalent employees (FTE) including 274 physicians and 828 nursing FTE.

**Workload.** In FY 2004, the medical center treated 66,358 unique patients. The medical center provided 107,333 inpatient days of care in the hospital and 27,241 inpatient days of care in the NHCU. The inpatient care workload totaled 9,594 discharges, and including nursing home patients, the average daily census was 404.8. The outpatient workload was 759,682 visits.

## Objectives and Scope of the CAP Review

**Objectives.** CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care and benefits services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility and regional office operations focusing on patient care, quality management, benefits, and financial and administrative controls.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

**Scope.** We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of patient care administration, QM, and general management controls. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met. We also followed up on the recommendations of our previous CAP review of the medical center (*Combined Assessment Program Review of VA Medical Center San Juan, Puerto Rico*, Report No. 02-00868-15, November 13, 2002).

The review covered facility operations for FY 2004 and FY 2005 through April 18, 2005, and was done in accordance with OIG standard operating procedures for CAP reviews. In performing the review, we inspected work areas; interviewed managers, employees, and patients; and reviewed clinical, financial, and administrative records. The review covered selected aspects of the following:

Colorectal Cancer Management	Medical Care Collections Fund
Contract Administration	Part-Time Physician Time and Attendance
Controlled Substances Accountability	Pressure Ulcer Clinical Practices
Environment of Care	Quality Management
Government Purchase Card Program	Supply Inventory Management
Information Technology Security	

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with the timeliness of services and quality of care. We made electronic survey questionnaires available to all medical center employees, and 181 employees responded. We also interviewed 36 patients during the review. The survey results were provided to medical center management.

During this review, we also presented 5 fraud and integrity awareness briefings to 1,004 medical center employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

We identified an organizational strength in the NHCU (page 4). Activities needing improvement are discussed in the Opportunities for Improvement section (pages 5-13). In this report we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. For the activities not discussed in the Opportunities for Improvement section, there were no reportable conditions.



## **Results of Review**

### **Organizational Strength**

#### **The Eden Alternative Improved the Quality of Life for NHCU Residents**

Some NHCU residents demonstrated physical and psychological improvement after implementation of the Eden Alternative, a program that incorporates animals, children, and plants into the NHCU environment. In February 2003, staff conducted research using the UCLA Loneliness Scale that revealed high levels of loneliness among NHCU residents.

In September 2003, 30 long-term care staff received 3 days of training and became certified Eden Alternative Associates. The staff created resident profiles utilizing the Eden Alternative Pleasures of Daily Life interviews, and the results revealed that residents wanted pets, children, and plants in the NHCU. In October 2003, the first cat was introduced into the NHCU environment; as of April 2005, the NHCU had a dog, two cats, a pair of lovebirds, and fish tanks. An outdoor gazebo, wheelchair accessible for gardening, is currently under construction. Children visit in after-school programs and participate in the adopt-a-grandparent program. NHCU staff do not wear laboratory coats and are addressed by first name only.

To assess the impact of the Eden Alternative, staff observed resident-animal interactions and documented the residents' verbal responses and/or behavioral changes. They documented anecdotes describing increased morale and satisfaction, which they believe indicated improved quality of life for some residents.

In the San Juan VA NHCU, plants, animals, and children revitalized a setting once associated with death and infirmity and decreased the loneliness of institutional care. NHCU managers plan to assess the Eden Alternative's long-term relationship to and impact on patients' use of medication, mobility, pressure sores, and urinary tract infections.

## Opportunities for Improvement

### Information Technology – Security Needed Improvement

**Condition Needing Improvement.** The medical center did not effectively guarantee continuity of business operations, control access to critical IT resources, or segregate incompatible duties. Additionally, the VISN IT system did not force strong password requirements and intruder lockout features.

- Alternate Information Systems (AIS) Processing Site. The medical center did not establish an alternate processing site to ensure support for continued operations in the event a disaster rendered the facility unusable. We reported this issue in the previous CAP report.
- Disaster Recovery Teams. Contingency plans for the Local Area Network, Veteran Health Information System and Technology Architecture (VistA), and Private Branch Exchange systems did not identify and define the roles and responsibilities of disaster recovery team members, as required.
- Contract Employees. The Information Security Officer (ISO) and Chief of Information Resource Management (IRM) did not review and approve contract proposals for contract employees prior to award, as required by the VA Office of Acquisition and Materiel Management and Veterans Health Administration (VHA) policies. As a result, the ISO could not ensure that all contract employees requiring access to the medical center AIS received the appropriate background investigations and security training.
- Internet Usage Violations. Violations of VA Limited Personal Use of Government Equipment policy identified by the ISO were not fully resolved. During the period January 1, 2004, through April 11, 2005, there were 68 cases where employees misused Government equipment or the Internet. At the time of our review, Human Resource Management (HRM) records showed that 46 cases had been closed, 11 were pending, and the remaining 11 had no files available. Disciplinary action in the 46 closed cases ranged from termination to written counseling. In three cases, no action was taken because the employees' supervisors failed to respond to repeated requests from HRM. In one of the three cases, HRM had recommended that the employee be suspended for downloading about 750 sexually explicit files and for numerous violations of the limited personal use policy. After several attempts to get the employee's supervisor to agree to disciplinary action, the supervisor told HRM the employee was too valuable to suspend. HRM subsequently closed the case with no action being taken. We discussed these cases with the Medical Center Director and he agreed to review the cases and take appropriate actions.
- Segregation of Duties. The Chief of IRM did not sufficiently segregate responsibilities for the administration of system access controls and audit trails.

Nineteen AIS specialists had full administrative rights to make changes to system access controls and were also given the audit trail function. The National Institute of Standards and Technology (NIST) prohibits individuals from being responsible for both system access controls and system audit trail functions.

- Background Investigations. IRM did not request background investigations for three telecommunication specialists before granting them access to sensitive data, as required.
- Audit Trails. IRM staff and the ISO did not conduct reviews of audit trail records for adverse activity, such as overriding security controls and performing modifications to the AIS. In addition, AIS security plans did not describe how frequently audit trails were to be reviewed and what guidelines would be used to conduct those reviews, as required by NIST.

**Recommended Improvement Action(s) 1.** The VISN Director should ensure that the Medical Center Director requires that:

- a. An alternate AIS processing site is established.
- b. Contingency plans identify the roles and responsibilities of disaster recovery team members.
- c. The ISO and IRM management review contract proposals prior to awarding contracts.
- d. HRM appropriately resolves all cases involving violations of VA Limited Personal Use of Government Equipment policy.
- e. Duties for administration of system access controls and audit trail functions are properly segregated.
- f. Background investigations are completed for all required positions.
- g. AIS security plans detail audit trail monitoring, analysis, and reporting procedures.

The VISN Director and the Medical Center Director agreed with the findings and recommendations and provided acceptable improvement plans. The Medical Center Director reported that back-up tapes for mission critical systems will be sent to the Miami VAMC which will be the alternate AIS processing site in the event of a disaster. Contingency plans identify the roles and responsibilities of disaster recovery team members. The ISO and IRM management will review contract proposals prior to awarding contracts. HRM will provide consistent application of disciplinary/adverse actions in incidents regarding misuse of government property and appropriately resolve all cases pending at the time of the OIG inspection. Duties for administration of system access controls and audit trail functions are properly segregated. Human Resources

submitted all required documentation and background investigation requests. The AIS security plan was revised to detail audit trail monitoring, analysis, and reporting procedures. We will follow up on the planned actions until they are completed.

## **Supply Inventory Management – Inventory Controls Needed Improvement**

**Condition Needing Improvement.** Acquisition and Materiel Management Service (A&MMS) staff did not effectively use the Generic Inventory Package (GIP) system to manage inventory levels. We found that GIP records did not accurately reflect the inventory control points' (ICPs) inventory balances and stock items usage data. This significantly decreased the utility of the GIP system.

A&MMS established ICPs for Supply Processing and Distribution (SPD), Supply Warehouse, Office Supplies, Environmental Management Service (EMS), and Engineering Service. As of February 28, 2005, GIP records showed that the 5 ICPs reported 3,205 stock items, valued at about \$1.6 million, including 1,306 stock items that exceeded a 30-day supply by about \$875,000.

Inaccurate Inventory Balances. We reviewed a judgment sample of 62 stock items for the 5 ICPs, valued at \$402,234, and found that inventory records were not accurate for 43 items (69 percent). Error rates for each ICP were:

- SPD 67 percent
- Supply Warehouse 80 percent
- Office Supplies 55 percent
- EMS 100 percent
- Engineering Service 56 percent

Our physical count of the 43 items found that 24 were overstated by \$100,145 (less stock on hand than recorded in GIP) and 19 were understated by \$66,611 (more stock on hand than recorded in GIP). While reconciling our count to the inventory records, we also found that GIP contained inaccurate cost information for some items. For example, plastic flashlights had a reported unit value of \$290, while the actual unit value was \$6.05. VA policy requires a 90 percent minimum accuracy rate for inventories.

Inadequate Usage Data. As of February 28, 2005, GIP had no usage data for 1,588 (71 percent) of the 2,228 stock items for 4 ICPs, as shown below:

ICPs	Stock Items		
	Total Number	Number with No Usage Data	Percent with No Usage Data
Supply Warehouse	784	404	51.5
Office Supplies	232	63	27.2
EMS	135	45	33.3
Engineering Service	1,077	1,076	99.9
<b>Total</b>	<b>2,228</b>	<b>1,588</b>	<b>71.3</b>

We found that A&MMS staff had entered usage data in SPD's ICP. However, the lack of usage data rendered GIP virtually useless for over 70 percent of the stock items in the remaining four ICPs. Because of the large discrepancies between the GIP inventory records and our physical counts of stock items on hand and the lack of usage data in GIP for four ICPs, we could not determine the amount of stock on hand that exceeded VHA's 30-day supply requirement. Once inventory records have been corrected and usage data has been entered into GIP, A&MMS staff should reduce the amount of stock on hand to the 30-day supply level.

Based on our review and discussion with A&MMS staff, these conditions occurred because:

- GIP had not been fully implemented.
- All replenishments, including user service requests, and purchases by non-A&MMS purchase cardholders of the ICP stock items, were not entered into GIP.
- Staff were not adequately trained in the use of GIP.

**Recommended Improvement Action(s) 2.** The VISN Director should ensure that the Medical Center Director requires that:

- GIP is fully implemented for all ICPs and GIP records contain accurate inventory balances.
- Staff processes purchase requests for recurring stock items using GIP.
- ICP stock usage data is entered into GIP.
- Stock levels are reduced to a 30-day supply level.
- Staff receive appropriate GIP training.

The VISN Director and the Medical Center Director agreed with the findings and recommendations and provided acceptable improvement plans. The Medical Center Director reported that GIP will be fully implemented for all ICPs and GIP records will contain accurate inventory balances. Logistics staff will process purchase requests for recurring stock items using GIP. ICP stock usage data is entered into GIP. A waiver was requested for a 60-day supply level due to the difficulty in meeting the 30-day supply level resulting from the location of Puerto Rico. The VISN Chief Logistics Officer gave verbal approval, and a written response is expected. GIP training provided by VISN 8 will be reinforced to attain a more efficient GIP operation. We will follow up on the planned actions until they are completed.

## **Government Purchase Card Program – Controls Needed Improvement**

**Condition Needing Improvement.** The medical center needed to improve controls over the Government Purchase Card Program. During the 15-month period ending December 31, 2004, cardholders completed 60,152 transactions totaling about \$27 million. We found that the medical center had too many purchase cards and cards with excessive spending limits, and quarterly reviews of cardholder accounts were not completed.

Excessive Purchase Cards and Spending Limits. Cardholder usage and single spending limits of active purchase cards should be evaluated. The medical center had 106 cardholders who held 670 active cards. We found that many of the active cards were not needed and spending limits could be significantly reduced, as shown below:

- The 106 cardholders did not use 370 (55 percent) of the 670 active cards during the 15-month period ending December 31, 2004.
- Twenty-one cardholders held 412 of the 670 active cards with single spending limits ranging from \$25,000 to \$300,000, totaling about \$12.7 million in single spending limits.
- The 21 cardholders only used 149 (36 percent) of the 412 cards.
- The 21 cardholders did not have a single purchase that exceeded \$2,500 on 47 (32 percent) of the 149 cards.
- Eight of the 21 cardholders with 14 cards in use had single spending limits ranging from \$50,000 to \$100,000, yet never exceeded \$25,000 for a single purchase.
- The 21 cardholders' average transaction amount for the remaining 88 cards was about \$610.

Reducing the number of active cards and spending limits would improve internal controls and reduce the Government's risk and exposure to possible theft or misuse of the cards.

**Quarterly Reviews.** During the first quarter of FY 2005, A&MMS and Fiscal Service staffs only reviewed 21 (3 percent) of the 670 cardholders' accounts and the Austin Financial Service Center statistically sampled 9 cardholders' accounts. At the time of our review, VHA policy required that quarterly reviews be conducted of all cardholder accounts not included in the statistical sample. VHA issued new policy on quarterly reviews in June 2005, requiring that 25 percent of all accounts be reviewed each quarter. Because quarterly reviews were not being conducted as required, the conditions cited above went undetected.

**Recommended Improvement Action(s) 3.** The VISN Director should ensure that the Medical Center Director requires that:

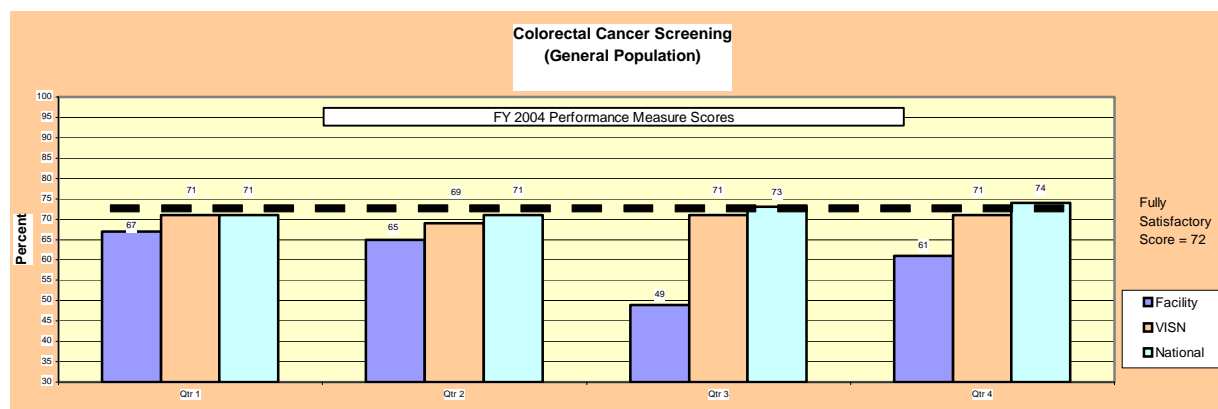
- a. The number of purchase cards and spending limits are reduced as appropriate.
- b. Quarterly reviews of cardholder accounts are conducted as required by VHA policy.

The VISN Director and the Medical Center Director agreed with the findings and recommendations and provided acceptable improvement plans. The Medical Center Director reported that the number of purchase cards and spending limits will be reduced as appropriate, and quarterly reviews of cardholder accounts will be conducted as required by VHA policy. We will follow up on the planned actions until they are completed.

## **Colorectal Cancer – Management Needed Improvement**

**Condition Needing Improvement.** Clinicians did not consistently conduct colorectal cancer (CRC) screening, provide timely gastroenterology (GI) consultation responses, or document that they notified patients of their diagnoses. Timely screening, diagnosis, notification, interdisciplinary treatment planning, and treatment are essential to appropriate management of CRC patients and optimal patient outcomes. The medical center provided timely Surgery and Hematology/Oncology consultative services, and developed coordinated treatment plans for CRC patients.

The following table illustrates the facility's performance in FY 2004 for CRC screening.



We assessed these items in a random sample of 12 patients who were diagnosed with CRC during FY 2004. Our review found that:

- 7 of 10<sup>1</sup> (70 percent) applicable patients were appropriately screened for colorectal cancer.
- 4 of 10<sup>2</sup> (40 percent) applicable patients received GI consultations within 30 days of request.
- 7 of 12 (58 percent) patients had documentation of notification of their diagnosis in the medical record.

The VHA CRC performance measure assesses the percent of patients screened for CRC according to prescribed criteria. Medical center policy states outpatient consults should be answered within 30 days of request. VHA's National Patient Rights and Responsibilities dictate that patients should be informed of their diagnoses and treatment plans.

Managers initiated a Process Action Team to address CRC screening deficiencies and conducted a review of CRC data to identify issues. The recommendations and the effectiveness of actions implemented are still being evaluated. GI clinical managers told us that diagnostic GI procedures were frequently not performed as quickly as desired because of increased workload and limited resources. Our review of workload from FY 2003 through FY 2004 confirmed an increase in GI consults and a subsequent increase in GI procedures. GI has developed a system to evaluate all consult requests and establish priorities for patient evaluation within 30 days, either at the medical center or on a fee basis, and to review consult tracking reports to validate timeliness. Additionally, managers told us that a third GI procedure room has been renovated, although staff have

<sup>1</sup> Two cases were excepted for not meeting review criteria.

<sup>2</sup> Two cases were excepted because GI consultations were not requested.



not been assigned. Managers advised us that providers notified patients of their diagnoses but did not consistently document the discussion in the medical record. Template note revisions to include these discussions are pending.

**Recommended Improvement Action 4.** The VISN Director should ensure that the Medical Center Director continues to follow-up on recommendations and proposed actions to address CRC screening, GI consultation response, and notification of patients regarding diagnosis.

The VISN Director and the Medical Center Director agreed with the findings and recommendations and provided acceptable improvement plans. The Medical Center Director reported that follow-up on recommendations and proposed actions to address CRC screening, GI consultation response, and notification of patients regarding diagnosis will be accomplished. We will follow up on the planned actions until they are completed.

## **QM – Completion of Patient Safety Aggregate Reviews Needed Improvement**

**Condition Needing Improvement.** QM staff did not conduct aggregate root cause analyses (RCAs) for missing patients, falls, or para-suicidal behaviors in FY 2004. The National Center for Patient Safety aggregate review schedule requires that medical centers complete these aggregate reviews according to specified time frames. San Juan VA Medical Center Policy 11-04-38, Patient Safety, requires that data are aggregated and reviewed by RCA teams according to the established time frames. Without appropriate review, facility managers could not be assured that patient safety process and system issues involving missing patients, falls, or para-suicidal behaviors were identified or that appropriate actions were implemented.

**Recommended Improvement Action 5.** The VISN Director should ensure that the Medical Center Director requires the completion of aggregate reviews as required by policy.

The VISN Director and the Medical Center Director agreed with the findings and recommendations and provided acceptable improvement plans. The Medical Center Director reported that aggregate reviews would be completed as required by policy. The Patient Safety Officer will oversee the team analysis report on aggregate reviews and follow up of implementation actions. We will follow up on the planned actions until they are completed.

## **Medical Care Collections Fund – Improved Procedures Could Increase Cost Recoveries**

**Condition Needing Improvement.** The medical center needed to improve procedures for recovering health care costs from insurance carriers. We found additional billing

opportunities totaling about \$12,700, with estimated collections of \$6,480 (\$12,656 x 51 percent<sup>3</sup>) that the medical center missed. Medical Care Collections Fund (MCCF) managers needed to improve timeliness of billing for fee-basis care,<sup>4</sup> and ensure that the billing contractor's determinations that episodes of care are not billable are correct.

The medical center had collected over \$9.7 million for FY 2004, which was 98 percent of the \$9.9 million goal. Medical center employees were responsible for coding VA and fee-basis episodes of patient care for potential cost recovery. After the coding is completed, information is provided to the billing and collection contractor, who prepares and sends third-party bills to health insurance carriers.

Fee-Basis Care. During the quarter ending December 31, 2004, the medical center paid 928 fee-basis claims totaling about \$158,600 to non-VA providers who provided medical care to patients with health insurance. Our review of a statistical sample of 12 potential billings totaling \$17,800 found 6 (50 percent) missed billing opportunities totaling \$11,700. Billing opportunities for these six episodes of fee-basis care were lost because MCCF staff did not bill for fee-basis care within the insurance carriers' 90-day claim submission deadlines.

VA-Provided Care. The "Reasons Not Billable Report" for the quarter ending December 31, 2004, listed 193 episodes of care totaling \$53,300 that were determined to be not billable because of insufficient documentation, no documentation, or non-billable provider (residents). Our review of a sample of 50 episodes of care with potential billings totaling \$13,400 found that the billing contractor inappropriately classified 18 (36 percent) episodes as not billable when bills of collections totaling \$1,000 could have been issued. We also identified 29 other cases where the contractor cited the wrong reason why the case could not be billed.

**Recommended Improvement Action(s) 6.** The VISN Director should ensure that the Medical Center Director requires MCCF staff to:

- a. Improve the timeliness of billing reimbursable fee-basis claims.
- b. Ensure that the billing contractor's determinations that episodes of care are not billable are correct.

The VISN Director and the Medical Center Director agreed with the findings and recommendations and provided acceptable improvement plans. The Medical Center Director reported that the timeliness of billing reimbursable fee-basis claims would be improved and San Juan has started using the Fee Basis Potential Cost Recovery VistA Option to identify fee basis cases for potential billing. All instances of episodes of care

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<sup>3</sup> We estimated collections using the medical center's FY 2004 collection rate of 51 percent.

<sup>4</sup> Fee-basis care is medical care provided to veterans by non-VA providers. VA reimburses the non-VA providers for the care.

that were determined to be unbillable are being reviewed to ensure that the correct determination was made. We will follow up on the planned actions until they are completed.

## VISN Director Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** September 1, 2005

**From:** Director, VA Sunshine Network (10N8)

**Subject:** **Combined Assessment Program Review of the VA Medical Center, San Juan, Puerto Rico, Project Number 2005-00709-HI-0096**

**To:** Director, Management Review and Administrative Service (10B5)

1. Thank you for the opportunity to review the draft report of the Combined Assessment Program Review of the VAMC, San Juan, Puerto Rico.
2. I have reviewed the report and the actions submitted by San Juan VAMC and concur with the recommendations and the actions taken.
3. Please contact Karen Maudlin at (727) 319-1063 if you have any questions.



George H. Gray, Jr.

Network Director, VISN 8

## Medical Center Director Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** September 1, 2005

**From:** Medical Center Director (672/00)

**Subject:** **Combined Assessment Program Review of the VA Medical Center, San Juan, Puerto Rico, Project Number 2005-00709-HI-0096**

**To:** VISN 8 Network Director

I thank you for allowing me the opportunity to review and respond to the subject report. We concur with the conclusions and recommendations presented by the Office of the Inspector General.

I attest as stated in the subject report that the Office of the Inspector General did a thorough review focusing in clinical as well as administrative areas. We were requested to provide volumes of documentation to be reviewed prior and during their visit. In addition, they were allowed access to the Computerized Patient Record System and other electronic systems to better review patient treatment management and administrative operations.

I present you the plan of action designed to correct those areas where we were provided with recommendations.

We are to be proud that the team of experts had no recommendations for improvements in most clinical management. Also, this team found no deficiencies in the areas of Contract Administration, Controlled Substances, Environment of Care, Part-Time Physician Time and Attendance, demonstrating that the San Juan VA Medical Center is committed to excellence.

## Medical Center Director Comments

The findings of this extensive review demonstrate the excellent quality of the services we provide to our veterans. I am proud of the services we provide to them. I am equally proud of our employees and of the significant contribution they make to the mission of our institution.

*(original signed by:)*

RAFAEL E. RAMIREZ, MD, FACP

## Medical Center Director Comments

### Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General Report:

#### OIG Recommendation(s)

**Recommended Improvement Action(s)** 1. The VISN Director should ensure that the Medical Center Director requires that:

- a. An alternate AIS processing site is established.

Concur      **Target Completion Date:** Complete

In the event that a disaster (internal or external) renders the facility unusable, San Juan will utilize the HP recoverall program. The backup tapes for mission critical systems will be sent to Miami VAMC (or other VISN 8 site as necessary) where VHA WAN connectivity is operational. This is the proven method for VistA COOP, as demonstrated in the Katrina disaster to re-establish the New Orleans VistA System in the Houston VAMC.

- b. Contingency plans identify the roles and responsibilities of disaster recovery team members.

Concur      **Target Completion Date:** Complete

Contingency plans identify the roles and responsibilities of disaster recovery team members. The team members have been identified for each system and are included in the local Standard Operating Procedure (SOP) on Separation of Duties Policy and the revised Contingency Plans for each system.

- c. The ISO and IRM management review contract proposals prior to awarding contracts.

## Medical Center Director Comments

Concur      **Target Completion Date:** September 23, 2005

The Information Security Officer, the Chief Information Resource Management Service, the Human Resources Manager and the Business Office Manager are working on a new Center Memo to address the review of contract proposals in accordance with VHA Directive 0710 and 6210.

- d. HRM appropriately resolves all cases involving violations of VA Limited Personal Use of Government Equipment policy.

Concur      **Target Completion Date:** Complete

On April 21, 2005 the San Juan VA Medical Center Director informed the Human Resource Manager of his decision regarding the consistent application of disciplinary / adverse actions in incidents regarding misuse of government property, specifically data access / computer use. However, each case may have different circumstances, which warrant independent evaluation and decision.

Disciplinary / adverse actions for all incidents of misuse of government property, which involve use of computers for personal business and/or unauthorized data access are as follows: first offense: from admonishment to reprimand; second offense: from reprimand to seven (7) days suspension; and third offense: from 14-day suspension to discharge.

Disciplinary / adverse actions for all incidents of misuse of government property, which involves sexually explicit material to include jokes, pictures, etc. are as follows: first offense: from 1-day suspension to 3 days suspension; second offense: from 7-day suspension up to 14-days suspension; and third offense: from 30 day suspension to discharge.

The Human Resources Manager certifies that all incidents reported with supporting documentation from April 2005, will be processed in accordance with the established guidelines.



## Medical Center Director Comments

Disciplinary action was taken on all the cases that were pending at the time of the OIG inspection. Of the 22 cases that action was taken, two are in process, the remaining have been closed. The three (3) cases closed without action were reviewed according to the information provided to the OIG auditor. Upon evaluation of each case, disciplinary action was taken in one case. The other two cases were closed without action since the offense date was too old to sustain an action.

- e. Duties for administration of system access controls and audit trail functions are properly segregated.

Concur                      **Target Completion Date:** Complete

As previously mentioned the local SOP has been reviewed by the ISO and IRM and it has been upgraded to include the audit process in addition to the segregation of duties.

- f. Background investigations are completed for all required positions.

Concur                      **Target Completion Date:** Complete

All required documentation and background investigation requests have been submitted by HR.

- g. AIS security plans detail audit trail monitoring, analysis, and reporting procedures.

Concur                      **Target Completion Date:** Complete

The AIS security plan has been reviewed to detail audit trail monitoring, analysis and reporting procedures, and package has been submitted to the VISN ISO for proper action.

**Recommended Improvement Action(s) 2.** The VISN Director should ensure that the Medical Center Director requires that:

- a. GIP is fully implemented for all ICPs and GIP records contain accurate inventory balances.

## Medical Center Director Comments

Concur            **Target Completion Date:** March 31, 2006

- b. Staff processes purchase requests for recurring stock items using GIP.

Concur            **Target Completion Date:** December 2005

- c. ICP stock usage data is entered into GIP.

Concur            **Target Completion Date:** December 31, 2005

- d. Stock levels are reduced to a 30-day supply level.

Concur            **Target Completion Date:** Complete

- e. Staff receive appropriate GIP training.

Concur            **Target Completion Date:** December 31, 2005

GIP is fully implemented for all ICP as of July 2005. GIP records contained inaccurate inventories at the time of the CAP. It is also true that for any inventory spot check reconciliation you must stop receipt and sales in the inventory system to assure no transactions are being omitted. The checking of inventory balances was done while normal regular inventory transactions were taking place. In addition the samples taken were very small. We will continue doing inventories on a recurring basis to achieve or exceed the 90% VA policy requirement. Changes are being made in the organization to comply as soon as possible.

The Logistics section was not in control of the purchases made by the Inventory Control Points. These responsibilities have been assigned to Logistics Section effective July 2005. The hiring of Item Managers is on-going.

## Medical Center Director Comments

During the CAP visit we were transitioning into GIP implementation. Additional temporary personnel were hired to populate the inventory data items. New items reflect no usage data in GIP. The system will pick up usage data on a monthly basis. Organizational changes being made will establish accountability and responsibility for these transactions. Monitors will be established to comply with the Performance Measures for this function.

Due to our location, PR has difficulty meeting the 30 day supply levels. A waiver was requested for 60 days level of supplies for VAMC, San Juan, PR. A verbal approval was given by the VISN CLO. A written response is expected.

Our staff has received training in GIP provided by VISN 8 on March 9, 2005. Supervisor and ADPAC attended GIP Training at VAMC Bay Pines/Tampa, FL on May 23 – 27, 2005 and at Salt Lake City, Utah for the National Item File. We will reinforce this training to attain a more efficient GIP operation.

**Recommended Improvement Action(s) 3.** The VISN Director should ensure that the Medical Center Director requires that:

- a. The number of purchase cards and spending limits are reduced as appropriate.

Concur      **Target Completion Date:** December 31, 2005

- b. Quarterly reviews of cardholder accounts are conducted as required by VHA policy.

Concur      **Target Completion Date:** Complete

We will do a review of our cards and determine if any changes in limits need to be made and if cards need to be cancelled by October 2005.

## Medical Center Director Comments

The bulk of cards issued are to purchasing agents in contracting and logistics. Each purchasing agent has a card for each fund control point resulting in a large number of cards issued. We are actively recruiting item managers who will have specific accounts assigned to them. This will reduce the number of cards from 20 down to 3 or 4 per person.

Quarterly reviews of cardholder accounts are conducted as required by VHA policy. We created a new Purchase Card Audit form, which follows all the requirements of the VHA handbooks. This form has been reviewed by the VISN and approved.

We have created a local menu with all the options and templates necessary to do the audits. Training was given to all auditors in Fiscal. The menu includes:

- 1 Inquire Credit Charge (Local)
- 2 Single P.O. Reprint in P&C
- 3 Reprint a Purchase Card Form
- 4 Identify ET's to Purchase Card Order (Local)
- 5 ET-FMS Document Display
- 6 Purchase Card Transaction Status
- 7 Purchase Date vs PO date (Local)
- 8 PC Limits by Cardholder (Local)
- 9 Vendor Display
- 10 Purchase Order Display
- 11 Days of Reconciliation (Local)
- 12 Charges for Fiscal Audits (Local)
- 13 Purchase Card Audit Report (Local)
- 14 PC Audit Report (Local)
- 15 Active Cardholders (Local)

The audit of the second quarter was completed. All Austin FSC samples have also been completed for FY 05.

## Medical Center Director Comments

**Recommended Improvement Action 4.** The VISN Director should ensure that the Medical Center Director continues to follow-up on recommendations and proposed actions to address CRC screening, GI consultation response, and notification of patients regarding diagnosis.

Concur **Target Completion Date:** December 2006

On March 2005, we initiated a Health Failure Mode Effect Analysis (HFMEA) on Colorectal Cancer screening to treatment, to identify deficiencies, close gaps and recommend improvement actions. We have evaluated our patient population, maximized our in-house Gastroenterologists time for procedures, modified our physical and equipment infrastructure, and improved the consultation processes with available resources.

The screening process was evaluated and a flow chart was developed closing the gaps.

To improve the screening process we modified the colorectal cancer screening reminder used by Physicians, Nurse Practitioners and Nurses. In the modification, we reduced the laboratory requisites previously established for laboratory work up. In addition, a plan for patient education in colorectal cancer screening including FOBT, double contrast, barium enema, flexible sigmoidoscopy and colonoscopy was developed.

The plan was discussed and approved in the Performance Improvement Board meeting on May 2005. Another initiative was the reporting of positive FOBT to the ordering Provider as a critical value result.

Since demands for colorectal cancer exceeded our capacity, we are referring patients to the community for GI evaluations. The GI referral process has been standardized throughout the institution including fee basis. This will entail that the consult response time, the timeliness of initial evaluation and procedure (colonoscopy) plus the documentation of procedure

## Medical Center Director Comments

and biopsy results should be uniform and without delay throughout the outpatient GI clinics as well as the GI clinics contracted through fee basis.

To assure the prompt patient notification of diagnosis, GI Physicians are scheduling an appointment two weeks after the colonoscopy procedure. In this appointment, we notify patients about the diagnosis. The fee basis referral generates logistical difficulties also due to the lack of electronic medical records in the community with the resulting burden to VA personnel when results have to be scanned into CPRS to complete the medical records. We have found that documented notification of colon cancer diagnosis continues to be inconsistent. We expect to have consistent outcomes by December 2005.

The San Juan VA Healthcare Center has requested to be included in a national initiative to continue improving the performance of colorectal cancer screening, consultation response and notification of diagnosis. We volunteered to participate in the ACA Colorectal Cancer Collaborative Study. We are actually working with Phase I of the project. In our next face to face meeting (September 22, 2005), we will be discussing the outcomes and evaluating effectiveness of the improvement efforts.

**Recommended Improvement Action 5.** The VISN Director should ensure that the Medical Center Director requires the completion of aggregate reviews as required by policy.

Concur **Target Completion Date:** September 30, 2005

A one day RCA Aggregated Review Training was held in San Juan on August 2, 2005, sponsored by VISN 8 along with the VISN 8 Quality Management Officer and other resources. A total of 56 employees participated and committed to work on the RCA aggregated reviews during the next 2 years.

## Medical Center Director Comments

Aggregated Review Charters for Medication Errors, Falls, Parasuicidal Events and Missing patients have been given to staff to complete FY 05 reviews.

On June 3, 2005 the teams were chartered to prepare for the August 2, 2005 training. Training was completed and teams officially started working on their teams on August 5, 2005. Teams are to meet weekly or as they deem necessary for compliance with the 45 day timeframe allowed for completion. Teams are due for reporting to the San Juan VAMC leadership on September 23, 2005 to present the recommendations for approval and implementation.

The aggregated review team analysis report and follow up of implementation of actions will be overseen by the Patient Safety Officer (PSO). RCA actions status reports will be presented to the Performance Improvement Board for discussion.

**Recommended Improvement Action(s) 6.** The VISN Director should ensure that the Medical Center Director requires MCCF staff to:

- a. Improve the timeliness of billing reimbursable fee-basis claims.

Concur                      Target Completion Date: Complete

- b. Ensure that the billing contractor's determinations that episodes of care are not billable are correct.

Concur                      **Target Completion Date:** Complete

## **Medical Center Director Comments**

San Juan had just started using the Fee Basis Potential Cost Recovery VistA Option to ID fee basis cases in December 2004 due to various local health care insurance carrier restrictions. As of September 1, 2005 we are billing fee basis services up to August 15, 2005.

A monitor is in place for reviewing Reasons Not Billable Report on contractors bills cancelled. All instances of Reasons Not Billable are being reviewed to ensure that the correct determination was made. We are now running the report with all parameters to ensure all instances can be reviewed. Any lost opportunity which cited the incorrect reason will be deducted from contractors' invoice at VA's potential recovery rate.



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